

- Cardiology (290)
- Clinical haematology/oncology (171)
- Clinical pharmacology and toxicology (273)
- Clinical sciences (410)
- Dermatology (131)
- Endocrinology (174)
- Gastroenterology (183)
- Infectious diseases and STIs (212)
- Nephrology (104)
- Neurology (247)
- Ophthalmology (56)
- Psychiatry (59)
- Respiratory medicine (162)
- Rheumatology (134)

2600 MCQ with Illustrated Answer
Full Topics Note
14 Chapter

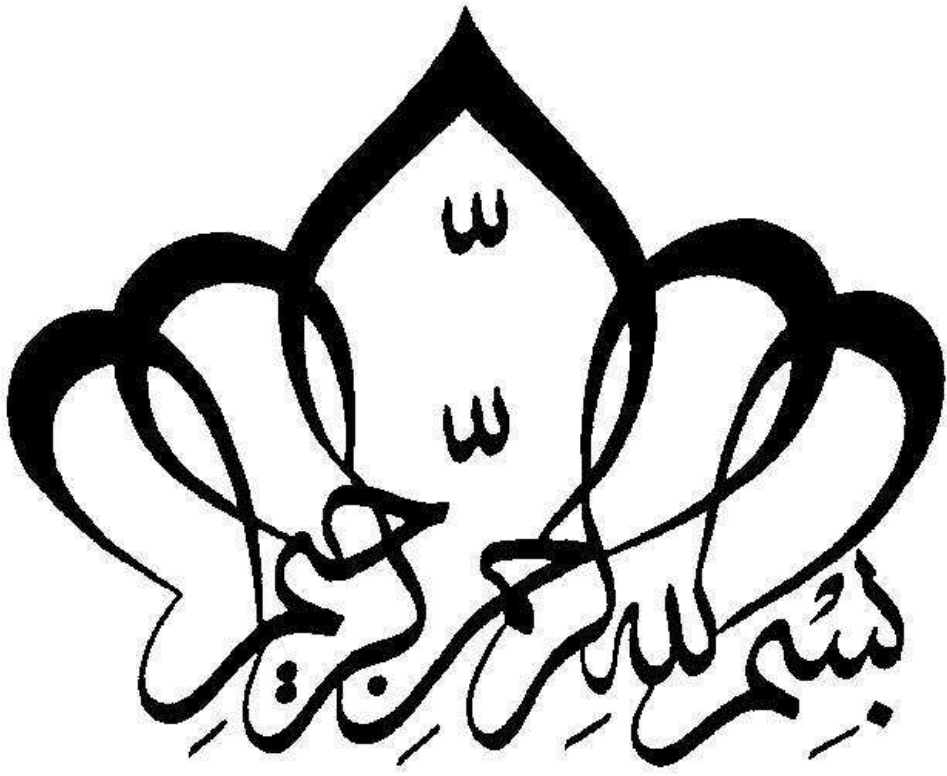
Psychiatry

P. M MCQ Bank **2017**



VISIT...

LANZAROTE
Caliente.COM



قَالُوا سُبْحَانَكَ لَا عِلْمَ لَنَا إِلَّا مَا عَلَّمْتَنَا
۞ إِنَّكَ أَنْتَ الْعَلِيمُ الْحَكِيمُ

إهداء

للكل آية من كتاب الله حفظناها ولكل معلومة قرأناها ونسيناها لعل الله يحمينا من النسيان ويروها إلينا
للكل شخص وعونا له في ظهر الغيب لعل الله أن يستجيب دعائنا
للكل مريض قرأ له ما أله لعل الله يشفيه ويعير إليه صحته وعافيته
للكل لحظة تألم بها أحببنا لعل الله لا يريهم الألم ولا يضييهم مرة أخرى
للكل موقف اجتجت به عيناى فلم تلبيانى لعل الله لا يضرنى بهما في حياتى
للكل حالم صاحب أهراء ومباوى لعل الله يحقق له مقاصده حتى يرضيه ويرضى عنه
للكل مجتهد لعل الله يجعل له من التوفيق أوفر حظ ونصيب ويهون له الأسباب كلها من حيث لا يدري من غير ضراء مضرة ولا فتنة مضلة
للكل من فقر شيئا في الحياة لعل الله يعيره إليه أو يعوضه بما يسعده
للكل شخص ابتعدنا عنه لعل الله يجمعه بمن هم أفضل منا
وأخيرا وليس آخرا لأهلنا لعل الله يجعلها لهم صرقة جارية ترو إليهم قليلا من فضلهم علينا وتكون سببا يلم شملنا تحت سقف واحد بعد أن
هجرتنا الحروب والمصائب

يقول أحد الصالحين

إِذَا رَأَيْتَ أَنَّ اللَّهَ وَفَقَكَ لِإِخْوَةِ تَعْيْنِكَ عَلَى الْخَيْرِ.. فَأَعْلَمْ أَنَّ اللَّهَ يَرِيدُ بِكَ خَيْرًا !! وَإِذَا وَفَقَكَ اللَّهَ لِلدُّعَاءِ.. فَأَعْلَمْ أَنَّ اللَّهَ يَرِيدُ أَنْ يُعْطِيَكَ !! وَإِذَا
وَفَقَكَ لِقَضَاءِ حَوَائِجِ النَّاسِ فَأَعْلَمْ أَنَّ لَكَ يَتَخَلَّى عَنْكَ !! وَإِذَا وَفَقَكَ اللَّهَ لِذِكْرِهِ.. فَأَعْلَمْ أَنَّكَ مُحِبٌّ !! .. وَإِذَا أَحْبَبَّكَ أَحَدٌ.. وَنَصَرَكَ.. وَأَيَّرَكَ..
وَأُسْتَجَابَ لِدُعَائِكَ !!

This issue of **MRCPPART1 MADE EASY 2017** contains the following:

- Full topic note.
- Around 2600 MCQs from **PM 2017 BANK** covering 14 chapter in internal medicine
- External links for the related guidelines (such as NICE, SIGN, RCP ...etc).
- Comments with illustrative pictures and links to external media.
- Most Recommended QBank for MRCP Part 1, Arab Board, Jordanian Board and other internal medicine assessment exams.

Please Note that

Each chapter begins with notes section. These notes are repeated under the Questions in the website. In these collections the notes are not repeated under each question except in some to avoid unnecessary repetition. For clarity and convenience the title of the related note is only mentioned after the comments in case the reader want to refer back to the respective note in the notes section.

The illustration below is to show and Example

☐	Minimal change disease
☐	Post-streptococcal glomerulonephritis
☐	Goodpasture's syndrome

Goodpasture's syndrome

- IgG deposits on renal biopsy
- anti-GBM antibodies

• These changes are characteristic of Goodpasture's syndrome.

[Discuss and give feedback](#)

Goodpasture's syndrome 

Comment of the Q

title of the note in case the reader want to refer back to the notes sections

MRCPPART1 MADE EASY 2017

Chapter	Number of Q
Cardiology	292
Clinical haematology/oncology	171
Endocrinology	174
Gastroenterology	183
Infectious diseases and STIs	212
Nephrology	104
Neurology	247
Respiratory medicine	162
Rheumatology	134
Clinical pharmacology and toxicology	273
Clinical sciences	410
Dermatology	131
Ophthalmology	56
Psychiatry	59

إعداد وتنسيق

M. HABAYEB

**Msc Internal. Medicine
Cairo University**

&

A. MURAD

لا تنسونا من صالح دعائكم

ما كان من خطأ فمن أنفسنا وما كان من توفيق فمن الله

تم بحمد الله وتوفيقه ومنه

جعل الله عملنا متقبلاً خالصاً لوجهه الكريم

Reference ranges

Reference ranges vary according to individual labs. All values are for adults unless otherwise stated

Full blood count

Haemoglobin	Men: 13.5-18 g/dl Women: 11.5-16 g/dl
Mean cell volume	82-100 fl
Platelets	150-400 * 10 ⁹ /l
White blood cells	4-11 * 10 ⁹ /l

Urea and electrolytes

Sodium	135-145 mmol/l
Potassium	3.5 - 5.0 mmol/l
Urea	2.0-7 mmol/l
Creatinine	55-120 umol/l
Bicarbonate	22-28 mmol/l
Chloride	95-105 mmol/l

Liver function tests

Bilirubin	3-17 umol/l
Alanine transferase (ALT)	3-40 iu/l
Aspartate transaminase (AST)	3-30 iu/l
Alkaline phosphatase (ALP)	30-100 umol/l
Gamma glutamyl transferase (γGT)	8-60 u/l
Albumin	35-50 g/l
Total protein	60-80 g/l

Other haematology

Erythrocyte sedimentation rate (ESR)	Men: < (age / 2) mm/hr Women: < ((age + 10) / 2) mm/hr
Prothrombin time (PT)	10-14 secs

Activated partial thromboplastin time (APTT)	25-35 secs
Ferritin	20-230 ng/ml
Vitamin B12	200-900 ng/l
Folate	3.0 nmol/l
Reticulocytes	0.5-1.5%
D-Dimer	< 400 ng/ml

Other biochemistry

Calcium	2.1-2.6 mmol/l
Phosphate	0.8-1.4 mmol/l
CRP	< 10 mg/l
Thyroid stimulating hormone (TSH)	0.5-5.5 mu/l
Free thyroxine (T4)	9-18 pmol/l
Total thyroxine (T4)	70-140 nmol/l
Amylase	70-300 u/l
Uric acid	0.18-0.48 mmol/l

Arterial blood gases

pH	7.35 - 7.45
pCO2	4.5 - 6.0 kPa
pO2	10 - 14 kPa

Lipids

Desirable lipid values depend on other risk factors for cardiovascular disease, below is just a guide:

Total cholesterol	< 5 mmol/l
Triglycerides	< 2 mmol/l
HDL cholesterol	> 1 mmol/l
LDL cholesterol	< 3 mmol/l

Chapter: Psychiatry

Alcohol withdrawal	Notes
Anorexia nervosa	Notes
Anorexia nervosa: features	Notes
Aphonia	Notes
Body dysmorphic disorder	Notes
Bulimia nervosa	Notes
Cognitive behavioural therapy	Notes
Cotard syndrome	Notes
De Clerambault's syndrome	Notes
Depression: screening and assessment	Notes
Electroconvulsive therapy	Notes
Grief reaction	Notes
Hypomania vs. mania	Notes
Korsakoff's syndrome	Notes
Othello's syndrome	Notes
Personality disorders	Notes
Post-concussion syndrome	Notes
Post-partum mental health problems	Notes
Post-traumatic stress disorder	Notes
Schizophrenia: epidemiology	Notes
Schizophrenia: features	Notes
Schizophrenia: management	Notes
Schizophrenia: prognostic indicators	Notes
Seasonal affective disorder	Notes
Selective serotonin reuptake inhibitors	Notes
Sleep paralysis	Notes
Suicide	Notes
Tricyclic antidepressants	Notes
Unexplained symptoms	Notes

Alcohol withdrawal

Mechanism

- chronic alcohol consumption enhances GABA mediated inhibition in the CNS (similar to benzodiazepines) and inhibits NMDA-type glutamate receptors
- alcohol withdrawal is thought to lead to the opposite (decreased inhibitory GABA and increased NMDA glutamate transmission)

Features

- symptoms start at 6-12 hours
- peak incidence of seizures at 36 hours
- peak incidence of delirium tremens is at 72 hours

Management

- benzodiazepines
- carbamazepine also effective in treatment of alcohol withdrawal
- phenytoin is said not to be as effective in the treatment of alcohol withdrawal seizures

Anorexia nervosa

Anorexia nervosa is the most common cause of admissions to child and adolescent psychiatric wards.

Epidemiology

- 90% of patients are female
- predominately affects teenage and young-adult females
- prevalence of between 1:100 and 1:200

Diagnosis (based on the DSM-IV criteria)

- person chooses not to eat - BMI < 17.5 kg/m², or < 85% of that expected
- intense fear of being obese
- disturbance of weight perception
- amenorrhoea = 3 consecutive cycles

The prognosis of patients with anorexia nervosa remains poor. Up to 10% of patients will eventually die because of the disorder.

Anorexia nervosa: features

Anorexia nervosa is associated with a number of characteristic clinical signs and physiological abnormalities which are summarised below

Features

- reduced body mass index
- bradycardia
- hypotension
- enlarged salivary glands

Physiological abnormalities

- hypokalaemia
 - low FSH, LH, oestrogens and testosterone
 - raised cortisol and growth hormone
 - impaired glucose tolerance
 - hypercholesterolaemia
 - hypercarotinaemia
 - low T3
-

Aphonia

Aphonia describes the inability to speak. **Causes include:**

- recurrent laryngeal nerve palsy (e.g. Post-thyroidectomy)
 - psychogenic
-

Body dysmorphic disorder

Body dysmorphic disorder (sometimes referred to as dysmorphophobia) is a mental disorder where patients have a significantly distorted body image

Diagnostic and Statistical Manual (DSM) IV criteria:

- Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive
- The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa)

Bulimia nervosa

Bulimia nervosa is a type of eating disorder characterised by episodes of binge eating followed by intentional vomiting

Management

- referral for specialist care is appropriate in all cases
- cognitive behaviour therapy (CBT) is currently considered first-line treatment
- interpersonal psychotherapy is also used but takes much longer than CBT
- pharmacological treatments have a limited role - a trial of high-dose fluoxetine is currently licensed for bulimia but long-term data is lacking

External Links

[Clinical Knowledge Summaries](#)

Eating disorder guidelines

Cognitive behavioral therapy

Main points

- useful in the management of depression and anxiety disorders
- usually consists of one to two hour sessions once per week
- should be completed within 6 months
- patients usually get around 16-20 hours in total

External Links

[Royal College of Psychiatrists](#)

Cognitive behavioural therapy

Cotard syndrome

Cotard syndrome is a rare mental disorder where the affected patient believes that they (or in some cases just a part of their body) is either dead or non-existent. This delusion is often difficult to treat and can result in significant problems due to patients stopping eating or drinking as they deem it not necessary.

De Clerambault's syndrome

De Clerambault's syndrome, also known as erotomania, is a form of paranoid delusion with an amorous quality. The patient, often a single woman, believes that a famous person is in love with her.

Depression: screening and assessment

Screening

The following two questions can be used to screen for depression:

- 'During the last month, have you often been bothered by feeling down, depressed or hopeless?'
- 'During the last month, have you often been bothered by having little interest or pleasure in doing things?'

A 'yes' answer to either of the above should prompt a more in depth assessment.

Assessment

There are many tools to assess the degree of depression including the Hospital Anxiety and Depression (HAD) scale and the Patient Health Questionnaire (PHQ-9).

Hospital Anxiety and Depression (HAD) scale

- consists of 14 questions, 7 for anxiety and 7 for depression
- each item is scored from 0-3
- produces a score out of 21 for both anxiety and depression
- severity: 0-7 normal, 8-10 borderline, 11+ case
- patients should be encouraged to answer the questions quickly

Patient Health Questionnaire (PHQ-9)

- asks patients 'over the last 2 weeks, how often have you been bothered by any of the following problems?'
- 9 items which can then be scored 0-3
- includes items asking about thoughts of self-harm
- depression severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

NICE use the **DSM-IV** criteria to grade depression:

- 1. Depressed mood most of the day, nearly every day
- 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
- 3. Significant weight loss or weight gain when not dieting or decrease or increase in appetite nearly every day
- 4. Insomnia or hypersomnia nearly every day
- 5. Psychomotor agitation or retardation nearly every day
- 6. Fatigue or loss of energy nearly every day
- 7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- 8. Diminished ability to think or concentrate, or indecisiveness nearly every day
- 9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Subthreshold depressive symptoms	Fewer than 5 symptoms
Mild depression	Few, if any, symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment
Moderate depression	Symptoms or functional impairment are between 'mild' and 'severe'
Severe depression	Most symptoms, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms

External Links

[SAMHSA-HRSA Center for Integrated Health Solutions](#)

PHQ 9 form

Electroconvulsive therapy

Electroconvulsive therapy is a useful treatment option for patients with severe depression refractory to medication or those with psychotic symptoms. The only absolute contraindications is raised intracranial pressure.

Short-term side-effects

- headache
- nausea
- short term memory impairment
- memory loss of events prior to ECT
- cardiac arrhythmia

Long-term side-effects

- some patients report impaired memory

Grief reaction

It is normal for people to feel sadness and grief following the death of a loved one and this does not necessarily need to be medicalised. However, having some understanding of the potential stages a person may go through whilst grieving can help determine whether a patient is having a 'normal' grief reaction or is developing a more significant problem.

One of the most popular models of grief divides it into 5 stages.

- Denial: this may include a feeling of numbness and also pseudohallucinations of the deceased, both auditory and visual. Occasionally people may focus on physical objects that remind them of their loved one or even prepare meals for them
- Anger: this is commonly directed against other family members and medical professionals
- Bargaining
- Depression
- Acceptance

♦It should be noted that many patients will not go through all 5 stages.

♦Abnormal, or atypical, grief reactions are more likely to occur in women and if the death is sudden and unexpected. **Other risk factors include:** a problematic relationship before death or if the patient has not much social support.

Features of atypical grief reactions include:

- delayed grief: sometimes said to occur when more than 2 weeks passes before grieving begins
- prolonged grief: difficult to define. Normal grief reactions may take up to and beyond 12 months

Hypomania vs. mania

The presence of psychotic symptoms differentiates mania from hypomania

Psychotic symptoms

- delusions of grandeur
- auditory hallucinations

The following symptoms are common to both hypomania and mania

Mood

- predominately elevated
- irritable

Speech and thought

- pressured
- flight of ideas
- poor attention

Behaviour

- insomnia
- loss of inhibitions: sexual promiscuity, overspending, risk-taking
- increased appetite

External Links

[Clinical Knowledge Summaries](#)

Suspecting bipolar disorder

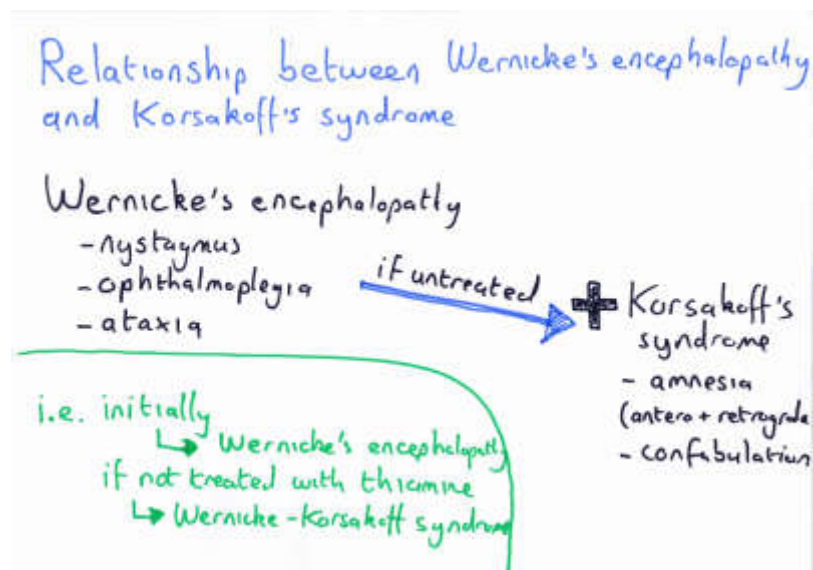
Korsakoff's syndrome

Overview

- marked memory disorder often seen in alcoholics
- thiamine deficiency causes damage and haemorrhage to the mammillary bodies of the hypothalamus and the medial thalamus
- in often follows on from untreated Wernicke's encephalopathy

Features

- anterograde amnesia: inability to acquire new memories
- retrograde amnesia
- confabulation



Othello's syndrome

Othello's syndrome is pathological jealousy where a person is convinced their partner is cheating on them without any real proof. This is accompanied by socially unacceptable behaviour linked to these claims.

Personality disorders

Disorder	Features
Antisocial	• Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest; • Deception, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure; • Impulsiveness or failure to plan ahead; • Irritability and aggressiveness, as indicated by repeated physical fights or assaults; • Reckless disregard for safety of self or others; • Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations; • Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
Avoidant	• Avoidance of occupational activities which involve significant interpersonal contact due to fears of criticism, or rejection. • Unwillingness to be involved unless certain of being liked • Preoccupied with ideas that they are being criticised or rejected in social situations • Restraint in intimate relationships due to the fear of being ridiculed • Reluctance to take personal risks due to fears of embarrassment • Views self as inept and inferior to others • Social isolation accompanied by a craving for social contact
Borderline	• Efforts to avoid real or imagined abandonment • Unstable interpersonal relationships which alternate between idealization and devaluation • Unstable self image • Impulsivity in potentially self damaging area (e.g. Spending, sex, substance abuse) • Recurrent suicidal behaviour • Affective instability • Chronic feelings of emptiness • Difficulty controlling temper • Quasi psychotic thoughts Borderline - think nightmare girlfriend/boyfriend
Dependent	• Difficulty making everyday decisions without excessive reassurance from others • Need for others to assume responsibility for major areas of their life • Difficulty in expressing disagreement with others due to fears of losing support

	• Lack of initiative • Unrealistic fears of being left to care for themselves • Urgent search for another relationship as a source of care and support when a close relationship ends • Extensive efforts to obtain support from others • Unrealistic feelings that they cannot care for themselves
Histrionic	• Inappropriate sexual seductiveness • Need to be the centre of attention • Rapidly shifting and shallow expression of emotions • Suggestibility • Physical appearance used for attention seeking purposes • Impressionistic speech lacking detail • Self dramatization • Relationships considered to be more intimate than they are
Narcissistic	• Grandiose sense of self importance • Preoccupation with fantasies of unlimited success, power, or beauty • Sense of entitlement • Taking advantage of others to achieve own needs • Lack of empathy • Excessive need for admiration • Chronic envy • Arrogant and haughty attitude Narcissistic - Steve Jobs's ex-wife thought he had this
Obsessive-compulsive	• Is occupied with details, rules, lists, order, organization, or agenda to the point that the key part of the activity is gone • Demonstrates perfectionism that hampers with completing tasks • Is extremely dedicated to work and efficiency to the elimination of spare time activities • Is meticulous, scrupulous, and rigid about etiquettes of morality, ethics, or values • Is not capable of disposing worn out or insignificant things even when they have no sentimental meaning • Is unwilling to pass on tasks or work with others except if they surrender to exactly their way of doing things • Takes on a stingy spending style towards self and others; and shows stiffness and stubbornness.

Paranoid	• Hypersensitivity and an unforgiving attitude when insulted • Unwarranted tendency to question the loyalty of friends • Reluctance to confide in others • Preoccupation with conspiratorial beliefs and hidden meaning • Unwarranted tendency to perceive attacks on their character
Schizoid	• Indifference to praise and criticism • Preference for solitary activities • Lack of interest in sexual interactions • Lack of desire for companionship • Emotional coldness • Few interests • Few friends or confidants other than family Schizoid - think Bruce Wayne/Batman from recent Christopher Nolan films
Schizotypal	• Ideas of reference (differ from delusions in that some insight is retained) • Odd beliefs and magical thinking • Unusual perceptual disturbances • Paranoid ideation and suspiciousness • Odd, eccentric behaviour • Lack of close friends other than family members • Inappropriate affect • Odd speech without being incoherent

Post-concussion syndrome

Post-concussion syndrome is seen after even minor head trauma

Typical features include

- headache
- fatigue
- anxiety/depression
- dizziness

Post-partum mental health problems

Post-partum mental health problems range from the 'baby-blues' to puerperal psychosis.

The **Edinburgh Postnatal Depression Scale** may be used to screen for depression:

- 10-item questionnaire, with a maximum score of 30
- indicates how the mother has felt over the previous week
- score > 13 indicates a 'depressive illness of varying severity'
- sensitivity and specificity > 90%
- includes a question about self-harm

'Baby-blues'	Postnatal depression	Puerperal psychosis
Seen in around 60-70% of women Typically seen 3-7 days following birth and is more common in primips Mothers are characteristically anxious, tearful and irritable	Affects around 10% of women Most cases start within a month and typically peaks at 3 months Features are similar to depression seen in other circumstances	Affects approximately 0.2% of women Onset usually within the first 2-3 weeks following birth Features include severe swings in mood (similar to bipolar disorder) and disordered perception (e.g. auditory hallucinations)
Reassurance and support, the health visitor has a key role	As with the baby blues reassurance and support are important Cognitive behavioural therapy may be beneficial. Certain SSRIs such as sertraline and paroxetine* may be used if symptoms are severe** - whilst they are secreted in breast milk it is not thought to be harmful to the infant	Admission to hospital is usually required There is around a 20% risk of recurrence following future pregnancies

*paroxetine is recommended by SIGN because of the low milk/plasma ratio

**fluoxetine is best avoided due to a long half-life

External Links

[Edinburgh Postnatal Depression Scale](#)

Edinburgh Postnatal Depression Scale

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) can develop in people of any age following a traumatic event, for example a major disaster or childhood sexual abuse. It encompasses what became known as 'shell shock' following the first world war. One of the DSM-IV diagnostic criteria is that symptoms have been present for more than one month

Features

- re-experiencing: flashbacks, nightmares, repetitive and distressing intrusive images
- avoidance: avoiding people, situations or circumstances resembling or associated with the event
- hyperarousal: hypervigilance for threat, exaggerated startle response, sleep problems, irritability and difficulty concentrating
- emotional numbing - lack of ability to experience feelings, feeling detached

from other people

- depression
- drug or alcohol misuse
- anger
- unexplained physical symptoms

Management

- following a traumatic event single-session interventions (often referred to as debriefing) are not recommended
- watchful waiting may be used for mild symptoms lasting less than 4 weeks
- military personnel have access to treatment provided by the armed forces
- trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) therapy may be used in more severe cases
- drug treatments for PTSD should not be used as a routine first-line treatment for adults. If drug treatment is used then paroxetine or mirtazapine are recommended

External Links

[NICE](#)

2005 PTSD guidelines

Schizophrenia: epidemiology

Risk of developing schizophrenia

- monozygotic twin has schizophrenia = 50%
- parent has schizophrenia = 10-15%
- sibling has schizophrenia = 10%
- no relatives with schizophrenia = 1%

External Links

[NICE](#)

2014 Schizophrenia guidelines

Schizophrenia: features

Schneider's first rank symptoms may be divided into auditory hallucinations, thought disorders, passivity phenomena and delusional perceptions:

Auditory hallucinations of a specific type:

- two or more voices discussing the patient in the third person
- thought echo
- voices commenting on the patient's behaviour

Thought disorder*:

- thought insertion
- thought withdrawal
- thought broadcasting.

Passivity phenomena:

- bodily sensations being controlled by external influence
- actions/impulses/feelings - experiences which are imposed on the individual or influenced by others.

Delusional perceptions

- a two stage process) where first a normal object is perceived then secondly there is a sudden intense delusional insight into the objects meaning for the patient e.g. 'The traffic light is green therefore I am the King'.

Other features of schizophrenia include

- impaired insight
- incongruity/blunting of affect (inappropriate emotion for circumstances)
- decreased speech
- neologisms: made-up words
- catatonia
- negative symptoms: incongruity/blunting of affect, anhedonia (inability to derive pleasure), alogia (poverty of speech), avolition (poor motivation)

*occasionally referred to as thought alienation

External Links

[NICE](#)

2014 Psychosis and schizophrenia in adults

Schizophrenia: management

NICE published guidelines on the management of schizophrenia in 2009.

Key points:

- oral atypical antipsychotics are first-line
- cognitive behavioural therapy should be offered to all patients
- close attention should be paid to cardiovascular risk-factor modification due to the high rates of cardiovascular disease in schizophrenic patients (linked to antipsychotic medication and high smoking rates)

External Links

[NICE](#)

2014 Psychosis and schizophrenia in adults: treatment and management

Schizophrenia: prognostic indicators

Factors associated with poor prognosis

- strong family history
- gradual onset
- low IQ
- premorbid history of social withdrawal
- lack of obvious precipitant

External Links

[NICE](#)

2014 Schizophrenia guidelines

Seasonal affective disorder

Seasonal affective disorder (SAD) describes depression which occurs predominately around the winter months. SAD should be treated the same way as depression, therefore as per the NICE guidelines for mild depression, you would begin with psychological therapies and follow up with the patient in 2 weeks to ensure that there has been no deterioration. Following this an SSRI can be given if needed. In seasonal affective disorder, you should not give the patient sleeping tablets as this can make the symptoms worse. Finally, the evidence for light therapy is limited and as such it is not routinely recommended.

Selective serotonin reuptake inhibitors

Selective serotonin reuptake inhibitors (SSRIs) are considered first-line treatment for the majority of patients with depression.

- citalopram (although see below re: QT interval) and fluoxetine are currently the preferred SSRIs
- sertraline is useful post myocardial infarction as there is more evidence for its safe use in this situation than other antidepressants
- SSRIs should be used with caution in children and adolescents. Fluoxetine is the drug of choice when an antidepressant is indicated.

Adverse effects

- gastrointestinal symptoms are the most common side-effect
- there is an increased risk of gastrointestinal bleeding in patients taking SSRIs. A proton pump inhibitor should be prescribed if a patient is also taking a NSAID
- patients should be counselled to be vigilant for increased anxiety and agitation after starting a SSRI
- fluoxetine and paroxetine have a higher propensity for drug interactions

Citalopram and the QT interval

- the Medicines and Healthcare products Regulatory Agency (MHRA) released a warning on the use of citalopram in 2011
- it advised that citalopram and escitalopram are associated with dose-dependent QT interval prolongation and should not be used in those with: congenital long QT syndrome; known pre-existing QT interval prolongation; or in combination with other medicines that prolong the QT interval
- the maximum daily dose is now 40 mg for adults; 20 mg for patients older than 65 years; and 20 mg for those with hepatic impairment

Interactions

- NSAIDs: NICE guidelines advise 'do not normally offer SSRIs', but if given co-prescribe a proton pump inhibitor
- warfarin / heparin: NICE guidelines recommend avoiding SSRIs and considering mirtazapine
- aspirin: see above
- triptans: avoid SSRIs

◆Following the initiation of antidepressant therapy patients should normally be reviewed by a doctor after 2 weeks. For patients under the age of 30 years or at increased risk of suicide they should be reviewed after 1 week. If a patient makes a good response to antidepressant therapy they should continue on treatment for at least 6 months after remission as this reduces the risk of relapse.

◆When stopping a SSRI the dose should be gradually reduced over a 4 week period (this is not necessary with fluoxetine). Paroxetine has a higher incidence of discontinuation symptoms.

Suicide

Factors associated with risk of suicide following an episode of deliberate self harm:

- efforts to avoid discovery
- planning
- leaving a written note
- final acts such as sorting out finances
- violent method

These are in addition to standard risk factors for suicide

- male sex
- advancing age
- unemployment or social isolation
- divorced or widowed
- history of mental illness (depression, schizophrenia)
- history of deliberate self-harm
- alcohol or drug misuse

Tricyclic antidepressants

Tricyclic antidepressants (TCAs) are used less commonly now for depression due to their side-effects and toxicity in overdose. They are however used widely in the treatment of neuropathic pain, where smaller doses are typically required.

Common side-effects

- drowsiness
- dry mouth
- blurred vision
- constipation
- urinary retention

Choice of tricyclic

- low-dose amitriptyline is commonly used in the management of neuropathic pain and the prophylaxis of headache (both tension and migraine)
- lofepramine has a lower incidence of toxicity in overdose
- amitriptyline and dosulepin (dothiepin) are considered the most dangerous in overdose

More sedative	Less sedative
Amitriptyline Clomipramine Dosulepin Trazodone*	Imipramine Lofepramine Nortriptyline

*trazodone is technically a 'tricyclic-related antidepressant'

Unexplained symptoms

There are a wide variety of psychiatric terms for patients who have symptoms for which no organic cause can be found:

Somatisation disorder

- multiple physical SYMPTOMS present for at least 2 years
- patient refuses to accept reassurance or negative test results

Hypochondrial disorder

- persistent belief in the presence of an underlying serious DISEASE, e.g. cancer
- patient again refuses to accept reassurance or negative test results

Conversion disorder

- typically involves loss of motor or sensory function
- the patient doesn't consciously feign the symptoms (factitious disorder) or seek material gain (malingering)
- patients may be indifferent to their apparent disorder - la belle indifference - although this has not been backed up by some studies.

Dissociative disorder

- dissociation is a process of 'separating off' certain memories from normal consciousness
- in contrast to conversion disorder involves psychiatric symptoms e.g. Amnesia, fugue, stupor
- dissociative identity disorder (DID) is the new term for multiple personality disorder as is the most severe form of dissociative disorder

Munchausen's syndrome

- also known as factitious disorder
- the intentional production of physical or psychological symptoms

Malingering

- fraudulent simulation or exaggeration of symptoms with the intention of financial or other gain

External Links

[Royal College of Physicians](#)

2013 Functional neurological symptoms